IN THE MATTER OF	*	**BEFORE THE MARYLAND**
	*	
KAREN CARR	*	**BOARD OF NURSING**
	*	
License Number: DEM00025	*	
	*	

* *

ORDER FOR SUMMARY SUSPENSION OF DIRECT ENTRY MIDWIFE LICENSE
PURSUANT TO SECTION 10-226(c)(2) OF THE ADMINISTRATIVE PROCEDURE ACT

The Maryland Board of Nursing (the "Board") hereby orders the **SUMMARY SUSPENSION** of the Direct Entry Midwife license, license number **DEM00025**, of **KAREN CARR** (the "Respondent"), in the State of Maryland. The Board takes this action pursuant to the authority of Maryland Code Ann., State Government Article ("SG") § 10-226 (c) (2) (2021 Repl. Vol.), which provides:

> A unit may order summarily the suspension of a license if the unit:
> (i) finds that the public health, safety, or welfare imperatively requires emergency action; and
> (ii) promptly gives the licensee:
> 1. Written notice of the suspension, the finding and the reasons that support the finding; and
> 2. An opportunity to be heard.

The Board has reason, as set forth below, to find that the public health, safety, or welfare imperatively requires emergency action under SG § 10-226 (c) (2).

ORDER FOR SUMMARY SUSPENSION PURSUANT TO § 10-226(c)(2) OF THE STATE GOVERNMENT ARTICLE
CARR, KAREN: DEM00025

INVESTIGATIVE FINDINGS AND REASONS IN SUPPORT OF SUMMARY SUSPENSION

Based on investigatory information obtained by, received by, made known to and available to the Board, the Board has reason to believe that the following facts are true:[1]

1. On February 10, 2020, the Respondent was issued a Direct Entry Midwife (DEM) license in the State of Maryland. The Respondent's DEM license has an "active" status and is due to expire on October 28, 2023.

COMPLAINT

2. On December 3, 2021, the Board received a complaint from Patient, regarding the direct entry midwifery care provided by the Respondent and "for negligence of care that ended in my daughter being a stillborn." Patient submitted several documents and videos related to the complaint.[2]

3. Patient provided a written time line of her contact with the Respondent, which includes the following timeline on the day of delivery:

November 20th -

3:42 am: Called Karen to time them for an hour and call her back.
4:30 am: My Mom arrived at our home.
4:38 am: [Father] called her back to tell her that contractions were 2-3 minutes apart and 1-2 minutes long.
7: ish am: [Assistant] arrived. Says that Karen is running late because she had to go to another birth. [Assistant] did a fetal heart rate check.
8:00 am: Karen arrived.
9:18 am – 10ish am: My water broke in the pool sometime in this time frame. I was having some contractions causing me to have [involuntary] pushing. I felt [Baby] moving while in the pool, she was kicking and moving around. I know for sure she was still alive at this point.

[1]The statements regarding the Respondent's conduct identified herein are intended to provide the Respondent with reasonable notice of the asserted facts. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent.
[2] Patient (Complainant) submitted: a document titled [Baby's] Story which documents the timeline of events of her contact with the Respondent; and a document with descriptions of videos and pictures of events on November 20, 2021. The videos include one at the time of delivery and another of the Respondent performing CPR.

10:00 am: Got out of the tub. Karen went to check me I was fully dilated they never told me how effaced I was.

10:18 am – 1:33 pm: PUSHING

10:18 am: They saw the head and said it was time to start pushing. I was on the bed at this time. They had me push chin to chest holding my breath for the next 3 hours and 15 minutes. They told me to push on every contraction and multiple times even if I did not feel the need to push. They moved me in a bunch of different positions. Every contraction they told me "one more push" "you need to push harder".

12:00ish pm: About 2 hours in I begged Karen to help me. I wanted her to help me get the baby out. I asked several times while crying. She said there was nothing she could do to help but that I had to keep pushing.
Multiple occasions Karen looked at [Assistant] asking her if she had any ideas of what to do, asked [Assistant] for her opinion, and took her advice.
The heartbeat was only checked three times in the pushing stage. 2 of the checks were by [Assistant]. I saw Karen writing down the times of what was going on (timeline) on a chart during birth.

12:30ish pm: Karen kept feeling in and around baby's head. Specifically in one location at the top where the baby's head was crowning, like there was something of concern.

1:33 pm: [Baby] was born [posterior].
In the video you can hear Karen say "the baby is dead".
She immediately flips the baby back and forth multiple times. She does not suction, she does not hand the baby to me, she checks for a heartbeat and says there is not one.
She starts doing CPR but never suctioned out the baby's mouth. As she is doing CPR you can see the lungs are not filling with air. Karen tells [Assistant] to call 911. [Assistant] and Karen are doing CPR together but [Assistant] does not know how to do it and Karen is getting upset with her because she isn't doing it right. [Assistant] asked if Karen had oxygen. Karen said she didn't have it with her. Thankfully the EMTs and cops showed up to help.
I'd say 9 minutes after delivery I delivered the placenta by myself while sitting on the birthing stool watching them give CPR. There was a lot of blood. [Assistant] got me up and put me on the bed. As I laid down blood was just gushing out of me.
[Assistant] told Karen I was losing a lot of blood. Karen continued to work on [Baby] even though the EMTs were there working on her too. Karen told [Assistant] to give me Pitocin. [Assistant] said she didn't have any Pitocin. Karen said go get it out of my bag to [Assistant]. [Assistant] took the syringe and filled it up out of the [vial] with a blue cap. [Assistant] administered the Pitocin in my left upper thigh.
The EMTs wanted to take me to the hospital but Karen kept forcefully refusing for me to go. Karen said "she is not going to the hospital". Every time the EMTs would try to talk to me about it Karen would cut them off and answer for me. Ultimately I listened to Karen and did not go.

She then checked to see if I needed stitches. She was not sure and asked [Assistant] for advice on what I needed. Ultimately Karen did NOT do stitches.
Karen never inspected the placenta [Assistant] did.
4ish pm: Karen left without saying goodbye to any of us except [Assistant]. She told [Assistant] she was going to another birth.

MEDICAL RECORDS: OB PROVIDER A

4. On May 20, 2021, Patient had a single OB visit with OB Practice A. Documentation of that visit, includes the following:

EGA: 14 1/7
EDC: 11/17/2021
Ht. 65 ins. Prepreg Wt.: 145 lbs. Wt.: 155.6 lbs. BMI: 25.99%
B/P: 100/62
Past surgical History: deviated septum, tonsillectomy, kidney stones-flushed out
Lab report 5/20/2021: Hgb/Hct - 13.1/38.6
Lab report 5/20/2021: Urine culture – 20,000-50,000 CFU/ML [organism identified]

MEDICAL RECORDS: OB PROVIDER B

5. On June 3, 2021, Patient's had a single visit to OB Practice B. Documentation of that visit includes the following:

EGA: 16 weeks 1 day
EDD: 11/17/2021
B/P 115/71
29-year-old gravida 1 para 0. Patient has UTI. She is currently on Macrobid.
HT 5 ft 5 ins WT: 160 lbs. 2 oz. BMI: 26.71

MEDICAL RECORDS: OB PROVIDER KAREN CARR

Prenatal Record:

6. The Respondent documented the following in a single document identified as Prenatal Record:

EDD 11/17/21
[Patient's History] none
[List any injuries, surgery, or hospitalization with dates] deviated septum, tonsillectomy, kidney stones [no dates documented]
[On any medications now?] Macrobid

Physical Exam[3] [not dated] Height: 5'5'' Pre-pregnancy Weight: 160 ½.
[Laboratory Results] documented lab results done by previous OB providers - "urinalysis 5/20/21 no growth".
Consult: [consultation with a CNM]
Chart Review: [undated-documented review of records from OB Provider A and OB Provider B] - "[Patient] is a low-risk patient and a good candidate for homebirths."

Prenatal Examinations

Date	Weeks gestation	Weight	Fundus (cm)	Presentation	BP	Urine alb./glu.	FHT[4]	Examiner	Remarks
6/12/21	17[2]	155	17	none recorded	123/78	none recorded	136	KC	none recorded
7/8/21	21	165	22	none recorded	112/69	none recorded	132	KC	none recorded
8/5/21	25	170	26 1/2	none recorded	108/64	none recorded	156	KC	None recorded
9/9/21	30	180	30	v	117/71	none recorded	148	KC	Hgb 10.8
9/22/21	32	none recorded	32	v	105/69	none recorded	144	KC	
10/7/21	34	190	34	v	100/60	none recorded	140	[RN]	c/o leg & abd. disc
10/28/21	37	196	39	v	118/78	none recorded	148	KC	
11/11/21	39	none reported	40 1/2	v	135/90	none reported	140	KC	G.B.S.
11/18/21	40[1]	none reported	39 1/2	v	128/72	none reported	140	KC	

Notes:
[undated] Initial p.n. 5/20/21 total 2 (from chart review)
10/7/21 note entry by RN.

7. The results of a lab test performed on November 11, 2021 was located in the records.

Birthing Record

8. The Respondent documented the following in a single document titled Birthing Record:

BABY
[Baby's name] Date: November 20, 2021 Time: 1:32 p (est.)
[Checked] stillbirth, vaginal delivery, delivery complete at home.
Apgar 1 min. 0 5 min. 0.
Wks. Gestation 40
Presentation: Cephalic-vertex
Position: [not documented]
Complications of labor: none

[3] This is the only physical examination documented in the Prenatal Records. During the Board's investigative interview, the Respondent stated she transcribed the physical exam from the prior OB provider's records and never did a physical exam of the patient.
[4] Fetal Heart Tones.

Cord cut: 1:50 pm
Resp. problems: stillborn – not breathing
FHT: range 120s – 160
Decelerations: none
Medications: no - epinephrine by EMTx2
MOTHER
Complications of pregnancy: none
Tears: Yes 1[0] Stitches: no
Length of labor: 11 12/60
1st stage 7 45/60 2nd stage 3 17/60 3rd stage 10/60
Rupture of membranes: 11/20/21 at 8:25 am
Vaginal lacerations: yes
Post-partum hemorrhage: 500 cc
Medication: Pitocin-1 amp IM x 1 [no time documented]

Notes on Labor and Delivery

Date/hr.	FHT	BP or Pulse	Dilation	Station	NOTES
11/20/21 7:35 a	138	[none recorded]	[none recorded]	[none recorded]	[Patient] in pool – active contractions started @ 1:30 am – bloody show
8:25 a	[none recorded]	[none recorded]	[none recorded]	[none recorded]	SROM clear - urge to push
8:57 a	132	[none recorded]	[none recorded]	[none recorded]	none recorded
10:15 a	156	[none recorded]	[none recorded]	[none recorded]	10 cm
11:15 a	160	[none recorded]	[none recorded]	[none recorded]	[none recorded]
11:55 a	144	[none recorded]	[none recorded]	[none recorded]	[none recorded]
12:35 p	136	[none recorded]	[none recorded]	[none recorded]	[none recorded]
1:16 p	128	[none recorded]	[none recorded]	[none recorded]	[none recorded]
[5]est. 1:32 p	[none recorded]	[none recorded]	[none recorded]	[none recorded}	Baby girl EMT called
est. 1:42 p		[none recorded]			Placenta 1:39p EMT arrived
est. 1:50 p		[none recorded]			Cord cut baby transferred to [Hospital] by EMT. Completely unresponsive to all resuscitation efforts
3:30 p					Midwife out – called to a birth [Patient] in shower assistant stayed
6:30 p					Assistant out
11/21/21 9:[illegible]a					p/c to [Patient] made plans to come out for a

[5] There was no documentation of the progression of labor between 1:16 pm and 1:32 pm, a period of approximately sixteen minutes.

					home visit in afternoon
3:27 p					Called assistant to inform her of mother in labor while in route asked her to call [Patient] to tell her I am unable to see her this afternoon
11/22/21 9:13 a					p/c to [Patient] – left message to plan home visit for afternoon – received call back from [Father] – [Patient] does not want me to come – she has seen OB at hospital – she will not be continuing care with me

Informed Consent and Disclosure ("Consent")

9. The Respondent and Patient signed the Consent on June 12, 2021. The Consent includes the following provisions:

3a. General outline of care offered by midwife, including visit schedule and other details of routine care:
Prenatal Care
I will see you once every 4 weeks from onset of care until 32 weeks of pregnancy. From 32 weeks until 40 weeks, I will increase visits for prenatal exams to every 2 weeks. This schedule may be modified as appropriate. At each visit I will perform a physical exam including blood pressure and appropriate blood and urine labs for the mother. For your baby, fundal height, fetal position, and fetal heart rate will be assessed with a fetoscope or doppler. I will address any questions you have about your pregnancy, birth, postpartum and newborn care. In between visits I am available to communicate with you by telephone.
Labor and Birth
During labor, I will monitor mother and baby to ensure that your labor and birth are within the parameters of normal and use my midwifery skills to facilitate the process of normal birth. I will provide immediate postpartum care by monitoring you.... I will remain at your home after the birth until all postpartum care is complete and satisfactory.
Postpartum Care
I will make 2 visits to your home following the birth. The first will be day 1 or 2 ....

3c. The following testing is routinely offered in pregnancy. I can discuss these tests with my midwife. My midwife can perform these tests or refer me out for them as desired:

- Urinalysis
- Urine culture
- Sexually transmitted infections including …syphilis
- Glucose screening test for gestational diabetes

3d. After discussing the benefits and risks with my midwife, I have the right to decline any tests, mandatory or otherwise.

EMERGENCY MEDICAL SERVICES (EMS) REPORTS (EXCERPTS)
E911 Time: 11/20/2021 13:35
Dispatch Received Call: 11/20/2021 13:35

EMS Unit A: November 20, 2021

10. I [EMT A] arrived on location POV for a reported newborn cardiac arrest. No other EMS providers were in the room on my arrival. There was a midwife on location doing CPR on the newborn. Infant was still connected to mom via the umbilical cord, which was white and pulseless. Infant was mottled with significant acrocyanosis. Pt also had significant bruising to the crown of her head. The midwife on scene (Karen Carr) stated that the patient was born at 40+3 weeks. She stated that the pregnancy and labor was uneventful w/no complications. Mother pushed for approximately 1.5 hours and delivered a pulseless and apneic baby girl at 1321. I took over mouth to mouth resuscitation of the infant while obtaining this history. AED pads were placed on the baby with no shock advised. CPR continued. [Chief] arrived and gave me an infant BVM so I could ventilate the patient. Patient was difficult to bag with mucous in the airway. Suction frequently performed with thick mucous being removed…. I continued bagging the patient and then attempted intubation… Unsuccessful on that attempt. Mucous membranes noted to be cold…. I took over compressions from the midwife….

[EMT B] …. Mother was moved after my arrival and the midwife cut the cord. CPR was being performed by the midwife and [EMT A] was bagging the baby…. CPR was initially started by the midwife at 1322 and the 911 call was placed at 1335…. Suctioning was done prior to each intubation attempt, a view was hard to obtain due to high amount of mucous in the airway…. One more attempt by [EMT A] was done at getting an ET tube placed but was again unsuccessful due to the high amounts of mucous…. Upon arrival at ER, …, report was given and care was transferred.

EMS Unit B: November 20, 2021

[EMT C] I acted as resource manager for this event…. Once child was transported, I then turned my attention to family/patient advocacy. I made direct verbal contact with the mother…. I also acknowledged that she was also a patient. She had just delivered and had a [sic] amount of bleeding[6] that should be transported to local ER for evaluate [sic] by a

[6] The Respondent documented in the Birthing Record a blood loss of 500 ml.

physician. The midwife immediately stated "she doesn't need to go". I again explained the reasoning for the request to the mother at which time she asked for some alone time with the midwife....
I then went back inside and was told the mother was refusing services from EMS for transport.

EMS Unit C: November 21, 2021

Dispatched for a walk-in with abdominal pains. Pt. is found in the engine bay of the firehouse with other providers.... Pt. is complaining of lower abdominal pain, concentrated on the left side. Pt. stated she gave birth yesterday and had complications during the delivery where the newborn was delivered limp and later passed away. Pt. signed a refusal from [unit] yesterday after the event. Pt. stated today she would like to be checked out for post childbirth and to make sure she has no complications from the incident.
20:47 HR 126
20:52 HR 125
20:57 HR 132
21:03 HR 116

HOSPITAL MEDICAL RECORDS: BABY

11. The ED Note provides the following information:

According to EMS, patient did not have any pulse they started CPR based on PALS, IO inserted, intubation attempts by EMS were unsuccessful.... [Pediatrician] intubated patient and patient received 2 more doses of epinephrine and we continued CPR. Still was no pulse at bedside, ultrasound was done, patient did not have any cardiac activities. Father is at bedside. We explained all of the process of the resuscitation from EMS to the ER and there was no objection or suggestion for continued CPR. Patient [pronounced] dead at 14:49.[7]

12. Baby's height and weight were documented as 21.65 in. and 4.2 kg (9.259 lbs.).

HOSPITAL MEDICAL RECORDS: PATIENT

13. Patient was admitted to the ED on November 21, 2021 at 2143 with complaint of abdominal pain. The ED records provide the following information:

History of Present Illness: She reports of gush of blood yesterday after the placenta was delivered however, the bleeding has subsided somewhat. She does report passing some clots. She believes she had a vaginal tear that was not repaired yesterday.
GU exam: there appears to be a grade 2 vaginal tear.
11/21//21 at 2122: Pulse: 130 B/P 138/95

[7] The Autopsy Report is pending.

THE BOARD'S INVESTIGATIVE INTERVIEWS

14. During an interview conducted on February 25, 2022, Patient's mother [Grandmother] reported that she was present during the delivery; at approximately 5:38 the patient was in the birthing pool and Assistant got there at 7:00 am and the Respondent arrived at 8:00 am.

15. Grandmother further reported that the patient was on the birthing stool at around 10:20 am and the baby's head was crowning at around 10:30 am; the Respondent performed the last fetal heart tone check at 1:16 pm (all previous checks were performed by Assistant) and the baby was delivered at 1:33 pm.; the baby was yellow in color and the blood was pooled at the top of the baby's head; the Respondent started CPR, yelled for Assistant to help her and told Assistant to call 911; after Assistant called 911, the Respondent started yelling at Assistant and Assistant handed the phone to Grandmother, who was instructed by the operator to count compressions, and she verbalized the instructions to the Respondent who stated "just tell them to get here".

16. Grandmother heard the "medical lady" from the EMS crew ask if Patient would go to the hospital. Grandmother heard the Respondent tell the crew member "[Patient] isn't going anywhere. She is staying here".

17. During an interview conducted on February 23, 2022, Patient's husband [Father] stated:

    i. On 11/20/21, he called the Respondent at 3:42 am to inform her that the patient was having contractions that were getting closer. Assistant arrived at the home between 6:50 am and 7:00 am and checked for FHTs, while the patient was in the birthing pool.
    ii. The Respondent arrived at approximately 8 am and Assistant checked the FHT again. Twenty to thirty minutes went by before the Respondent spoke to the patient.
    iii. During the 9 am hour, the Respondent ate her yogurt, viewed her Kindle and took a nap. Assistant was monitoring the patient who was still in the pool. Grandmother was also present.
    iv. Patient was experiencing "small pushes" while in the pool and got out of the pool at 10 am.

v. He went outside while the patient was checked for dilation. At approximately 10:20 am, Grandmother came outside and informed him that the patient was 10 cm and it was time to start pushing. The pushing continued until delivery.

vi. He believes the top of the baby's head was visible at 10:30 am and remained unchanged for the next 30 to 40 minutes. At 11:30 am there was small progress and the Respondent continued for three hours to instruct the patient to push.

vii. The last FHT check by Assistant was approximately 45 minutes to one hour before the FHT performed by the Respondent, which was 20 minutes before delivery. He sensed the Respondent was concerned by the look on her face. She placed the monitor to the side and quickly got the patient up from the bed and onto the birthing stool. The Respondent was positioned in front of the patient, Assistant was to the left of the patient and he was facing the Respondent.

viii. The baby was delivered with "face up" and unresponsive. The Respondent did not suction the baby and placed the baby on the ground stating "come on", checked for a heartbeat with a stethoscope, and began blowing into the baby's mouth and nose and called out "call somebody" as she performed CPR.

ix. Police arrived first followed by first responders. He went to the hospital with the baby.

x. He recalled the Respondent telling the first responder that the patient was not going to the hospital and that she didn't need to go to the hospital.

18. During an interview conducted on February 11, 2022, Assistant reported:

i. She is self-employed and started assisting the Respondent with home births in December 2020. She was present at Patient's home on November 20, 2021 and assisted with the delivery of the baby.

ii. On 11/20/21, she arrived at the patient's home before the Respondent because the Respondent had to check on another patient in labor. When she arrived, the patient was in the [birthing] pool and Father and Grandmother were present. She checked the FHTs which were in the 130s. The Respondent arrived at around 8 am.

iii. Between 9 am and 9:30 am, the patient started actively laboring but not pushing. At approximately 10:30 am the patient was actively pushing and got out of the pool. She checked FHT and it was in the 130s. After that all FHTs were checked by the Respondent. The patient was actively pushing from 10 am to 1:33 pm when the baby was delivered.

iv. At approximately 12:30 pm the baby's head was crowning and during that time, the Respondent asked if she wanted to feel the top of the baby's head. She got a feel of the area and described it as soft swelling on top of the baby's head.

v. On delivery, the baby's head was darker than the body, which was pale. The Respondent was giving the baby rescue breaths an she looked at the Respondent and asked to call 911. The Respondent stated "yes" and she immediately called 911 as the Respondent administered CPR. She provided all pertinent information to the operator and handed the phone to Grandmother.

vi. She administered Pitocin to the patient at the direction of the Respondent and she also examined the placenta.

19. During an interview conducted on March 4, 2022, under oath, the Respondent stated:

i. Patient contacted her because she wanted to have a home birth. The first visit was on June 12, 2021 and she discussed the parameters of care and the patient signed an informed consent.
ii. There were eight subsequent prenatal visits. She never performed a physical exam on the patient and did not do a pelvic exam until maybe the last visit.[8] The physical exam documented in the record was transcribed from the prior OB provider records.
iii. "My business is to check the baby and mother's blood pressure."
iv. One physical exam "is pretty standard for maternity care". "I just don't take a lot of notes."
v. The October 7, 2021 visit was done by an RN.
vi. She confirmed the documented presentation of the baby as "cephalic vertex" and described the presentation as "head down."
vii. The 1st stage of labor was from 1:30 am to 10:15 am; the second stage from 10:15 am to birth at 1:32 pm.
viii. Patient was pushing from 10:15 am to 1:32 pm.
ix. FHTs were checked by her and Assistant using a "open doppler" and the sound could be heard by everyone. She could not recall who did which FHT checks. The 1:16 pm FHT documentation on the birth record may have happened ten minutes before 1:16 pm.
x. The patient's B/P was not monitored during labor.
xi. There was no indication the baby was having problems during labor.
xii. She noticed crowning "minutes before the baby came out." She could not recall the direction of the baby's face (facing up or down) on delivery.
xiii. At delivery "I saw the baby did not have a lot going on." She confirmed there was no documentation of resuscitative efforts. She did mouth to mouth and chest compressions.
xiv. On delivery, she observed the "baby's color was pale" "very floppy" "just didn't look good" "limp not crying" "caput on head". She could not recall the color of the cord.
xv. She "palpated the heart with her hand and couldn't feel anything". She asked Assistant to listen with a stethoscope and she could not find anything.
xvi. She did not suction the baby because there "was no fluid in the baby's mouth."
xvii. Assistant called 911 and then helped with resuscitation.
xviii. She cut the cord at the request of EMS personnel and Assistant checked the cord vessels.
xix. She examined the patient after delivery and noted a 1st degree straight tear. She offered to suture the tear but the patient declined.
xx. She directed Assistant to administer Pitocin to the patient but stated she did not know if Assistant had prior experience administering Pitocin.
xxi. She denied discouraging the patient from going to the hospital.

SUMMARY

[8] There is no documentation of pelvic exams in the medical records.

20. The Respondent failed to meet the DEM standards of practice for the following reasons including, but not limited to:

Failure to monitor and evaluate the conditions of Patient and Baby:

a. The Respondent failed to complete routine prenatal care procedures and failed to respond to abnormal or absent findings that increased the risks of complications.

i. Failure to document any plan of care and counseling with patient during prenatal care and during labor: There was no documentation of any teaching, counseling, or communication between the Respondent and the patient during any of the prenatal, intrapartum, or postpartum care.

ii. Failure to record and accurately interpret intake biometrics and provide follow up care: The Respondent inaccurately documented the patient's pre-pregnancy weight (her PPW was 145 lbs., not 160 lbs.). Despite charting a height of 5'5'' and weight measurements, she failed to calculate Body Mass Index (BMI) to guide weight management counseling and risk management. The BMIs documented by the prior OB providers were both over 25, indicating that the patient was overweight. The prenatal flow cart demonstrates that by 37 weeks the patient had gained 51 lbs., over twice the upper limit of recommended weight gain in pregnancy. Weight measurements were not documented at the next two prenatal visits.

iii. Lack of 3rd trimester gestational diabetes and mandated syphilis screening, or documentation of offering the testing or the patient's refusal of testing: No documentation by the Respondent counseling and/or offering standard gestational diabetes (GDM) screening and Maryland-mandated syphilis screening at 28 weeks. With a BMI over 25 and an already less than optimal pattern of weight gain, the patient was at risk for gestational diabetes. The risks, benefits, and alternatives to screening for gestational diabetes and syphilis and declination by the patient were not documented. This was a missed opportunity for intervention to maintain a normal fetal weight, given that the baby was macrosomic, with a birth weight of 4.2 kg.

iv. Failure to diagnose anemia: On 9/9/21 at 30 weeks' gestation, the Respondent documented a hgb. of 10.8, which is considered anemia in the 3rd trimester and warranted iron supplementation and dietary counseling.

v. Failure to follow up on UTI in a patient with a history of renal calculi: The Respondent inaccurately documented "no growth" on the prenatal chart for the 5/20/21 urinalysis completed at OB Provider A. The patient was being treated for a UTI diagnosed by a urine culture (UC) and sensitivity, which the Respondent had reviewed. The Respondent failed to order a urine culture and sensitivity after the patient completed antibiotics and failed to repeat a UC later in pregnancy as was warranted in a patient with a history of renal calculi.

vi. Failure to respond to BP reading at 39 weeks gestation indicating hypertension: At the 11/11/21 visit, the patient's BP reading was 135/90. There was no documentation of: a discussion with the patient of the B/P

reading; urine testing for protein; lab work ordered; screening for pre-eclampsia symptoms, and a plan for follow up on the elevated B/P reading.

vii. Failure to conduct and document any appropriate physical exam and plan of care during labor: There were no maternal vital signs or physical exam documented during labor and birth. The measuring of maternal pulse rate is essential in order to differentiate maternal pulse rate from FHTs – ensuring that the FHT heard through doppler is fetal and not maternal pulse rate. The Respondent did not document a labor physical exam and essential findings, such as estimated fetal weight, fetal presentation, position, and pelvic exam findings. "10 cm" is not adequate pelvic examination documentation.

viii. Failure to manage postpartum hemorrhage documented as 500 ml: The Respondent inappropriately delegated to Assistant the administration of Pitocin and inappropriately allowed the patient to deliver her own placenta.

ix. Failure to allow the patient to transfer to the hospital upon recommendation of EMS: The patient, family and EMS personnel reported that when the EMS personnel recommended the patient go to the hospital for evaluation, the Respondent responded for the patient and stated the patient was not going to the hospital.

x. Failure to diagnose and document a 2nd degree vaginal laceration and failure to document any discussion with the patient of risks, benefits and alternatives to repair: The Respondent documented a 1st degree vaginal laceration. There is no documentation of a discussion with the patient regarding risks, benefits, and alternatives of suturing the laceration. During the patient's postpartum ER visit - the day after delivery, it was noted the patient sustained a 2nd degree vaginal tear.

xi. Failure to provide postpartum care or refer the patient to another provider for care: The patient had multiple postpartum risk factors – postpartum hemorrhage, a vaginal laceration and suffered the death of her baby. The Respondent left the patient within two hours after delivery to attend another birth. She canceled the visit on postpartum day 1 and made no arrangements for another midwife or provider to attend the patient.

b. **Failure to measure FHTs according to current intermittent auscultation guidelines. FHTs were documented only seven times in the almost 6 hours that the Respondent was present during labor.**
The Respondent documented no attempt to measure FHTs throughout contractions to evaluate the fetal tolerance of contraction stress, nor to compare fetal and maternal heart rates to ensure the FHTs were being measured accurately. The Respondent checked FHTs only **five times** in three hours of active pushing. Due to head compression and the risk for fetal intolerance of labor, second stage guidelines require auscultation throughout pushing every 5-15 minutes.

c. **Failure to respond appropriately to the fetus "lack of descent" despite reports that the head was visible at the perineum.**
The patient reported that at 10:18 am "they saw the head and said it was time to start pushing. I was on the bed at this time. They had me push chin to chest holding my breath for the next three hours and fifteen minutes".

The Respondent reported that the patient was pushing from 10:15 am to 1:32 pm. The Respondent allowed labor to continue when the patient was begging for help after two hours of pushing. The Respondent did not correctly identify the fetal position and what was actually seen at the perineum was the baby's scalp as it was pushed forward while the baby's skull remained deep in the pelvis in occiput posterior position and after hours the entire head was pushed forward.

There is no documentation of estimated fetal weight or fetal position during labor or in the birthing record. It appears from the birth video, Father's description and the patient's account that the baby was born "face up" and directly occiput posterior. The Respondent failed to diagnose the abnormal presentation despite evidence of arrest of fetal head descent.

The baby weighed 4.2 kg. With maternal weight gain of over 50 lbs., excessive fetal weight should have been suspected. Fetal macrosomia is associated with labor dystocia. The lack of fetal head descent despite hours of active pushing should have prompted the Respondent to reassess the plan to continue caring for the patient at home.

d. **Failure to conduct neonatal resuscitation procedures regarding suctioning and thermal management.**
The Respondent did not suction, had no bag or airway available and from the video of birth, did not provide any thermal management of the baby.

e. **Failure to correctly communicate to EMS personnel the length of the second stage of labor for emergency transfer.**
The Respondent informed EMS personnel that the patient was pushing for 1.5 hours, when the Respondent had documented the patient was "10 cm" at 10:15 am and the patient, the Respondent and Father reported active pushing for approximately three hours.

21. The Respondent practiced with blatant disregard of the Board's statutes and regulations that govern direct-entry midwifery practice, and the standards of practice of midwifery practice, resulting in devastating and tragic consequences for a family who placed their trust in the Respondent as a licensed direct-entry midwife. The Respondent's practice is grossly negligent and inconsistent with the generally accepted professional standards in the practice of direct-entry midwifery. The Respondent holds an active Maryland DEM license and the Respondent's continued practice poses a serious risk and danger to the public health, safety, and welfare.

CONCLUSION OF LAW

Based on the foregoing investigative findings and reasons, the Board finds that the public health, safety or welfare imperatively requires emergency action in this case pursuant to Md. Code Ann., State Govt. § 10-226 (c)(2) (2021 Repl. Vol.).

ORDER

It is hereby:

ORDERED that pursuant to the authority vested in the Board of Nursing by Maryland Code Ann., State Govt. § 10-226 (c)(2) (2021 Repl. Vol.), the Direct Entry Midwife license, license number **DEM00025,** of **KAREN CARR**, in the State of Maryland is hereby **SUMMARILY SUSPENDED**; and be it further

ORDERED that there will be a Show Cause Hearing on **April 27, 2022, at 11:00 AM** before the Board at the Maryland Board of Nursing offices, 4140 Patterson Avenue, Baltimore, Maryland 21215: and be it further

ORDERED that if, the suspension of the Respondent's license is continued following a Show Cause Hearing, the Respondent has the right to a full evidentiary hearing before the Board and a hearing will be scheduled before the Board if the Respondent submits a written request for an evidentiary hearing to the Board **no later than thirty (30) days from the date of the Board's written decision issued after the Show Cause Hearing;** and be it further

ORDERED that if the Respondent does not submit a timely written request to the Board for an evidentiary hearing within 30 days from the date of the Board's written decision issued after the Show Cause Hearing, the Respondent shall have waived all rights now and in the future to any hearing on the merits of the summary suspension of the Respondent's license and the factual allegations contained in this Order for Summary Suspension; and it is further

ORDER FOR SUMMARY SUSPENSION PURSUANT TO § 10-226(c)(2) OF THE STATE GOVERNMENT ARTICLE
CARR, KAREN: DEM00025

ORDERED that this Order for Summary Suspension shall remain in effect and the summary suspension of the Respondent's license shall continue until further Order of the Board; and it is further

ORDERED that this, "Order for Summary Suspension of Direct Entry Midwife License" is a **PUBLIC RECORD** pursuant to Md. Code Ann., General Provisions § 4-101 *et seq.*& § 4-333 (2019 Repl. Vol.).

March 28, 2022
Date

Karen E.B. Evans, MSN, RN-BC
The Executive Director's Signature
Appears on the Original Document

K
E
Maryland Board of Nursing